

337092

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 31535

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST Florence	MIDDLE V.	LAST Abbott	
2b. DATE OF DEATH		2c. HOUR	
MONTH DAY YEAR Nov 13, 85		2:50 PM	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	MONTH DAY YEAR 6 11 1884	101 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Carroll Co. MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Westminster	Westminster Nurs. & Conv. Center		HWF
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN
13a. STATE Md.		13b. Carroll	13c. Westminster
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Thomas Myers		FIRST MIDDLE LAST Keziah Armacost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		220-34-7256	
17. INFORMANT		ADDRESS	
Mr. James R. Abbott, Upperco, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardio-Pulmonary Failure			immediate
DUE TO, OR AS A CONSEQUENCE OF (b) ASD			76 years.
DUE TO, OR AS A CONSEQUENCE OF (c) Old age			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CUI			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8/15, 19 79, to 11/13, 19 85, that (1) (we) lost saw the deceased alive on 11/13/85, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
27b. SIGNATURE		DEGREE	
William R. Dourlu		MD	
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		27e. ADDRESS	
27c. DATE SIGNED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
11/13/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		11-15-85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
St. Paul's Cemetery		CITY OR TOWN COUNTY STATE Upperco Balto Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS Elaine Funeral Home, H AMPSTEAD, MD.		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

250-34-7526 Mr. James R. Abbot

Myers
Keshiah

Carroll Westminister * 1234 Washington

er Westminister Nurs. & Conv. Center HWP

USA * Carroll Co.

White

101

340036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 3 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDITH C. BALL			2a. DATE OF DEATH MONTH DAY YEAR 11 30 85		2b. HOUR 8:55 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 12 94		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairhaven		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Jerome Cherry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Metz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --		17. SOCIAL SECURITY NO. 220-50-1929	
18. INFORMANT ADDRESS Self (chart)							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **DEGENERATIVE DEMENTIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **MALNUTRITION**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 83 , to 11/30 , 19 85 , that (I) (we) last saw the deceased alive on 11/30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ellis Mez MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIS MEZ				22e. ADDRESS 1425 Liberty Rd. Eldersburg, MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/85		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR STEWART & MOWEN CO., 108 W. North Ave. 21201				25a. DATE REC'D. BY REGISTRAR DEC 4 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be evaluated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonated pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

EDITH	C.	END	11	30	32	8:55 AM
Female	White	03	12	94		
Maryland	U.S.	X			Carroll County	
Dykesville	Fairhaven				Housewife	
Maryland	Halitore	XY				
Lawrence	Cherry	Fannie				
No	---	200-20-1025	Self (chart)			

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

322053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 3 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter R. Barr			2a DATE OF DEATH MONTH DAY YEAR Nov. 5, 1985		2b HOUR 1 p M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1917		
6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.				
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b CITIZEN OF WHAT COUNTRY? U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10 CITY OR TOWN OF DEATH Westminster		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		
12b KIND OF BUSINESS OR INDUSTRY Gas & Electric		13a STATE Md.		13b COUNTY Balto.		
13c CITY OR TOWN Reisterstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 152 Westminster Rd. 21136		
14 FATHER'S NAME FIRST MIDDLE LAST George L. Barr		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Etta Smith				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-01-1733		17 INFORMANT ADDRESS 152 Westminster Rd., Doris Barr Reisterstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF, (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 77</u> to <u>11/5 85</u> , that (I) (we) lost <u>lost</u> above, (I) (we) did not view the body after death.				
22b. SIGNATURE <i>William</i>		DEGREE		22c. DATE SIGNED 11/7/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William		22e. ADDRESS Randall House, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto., Md.		24 FUNERAL DIRECTOR NAME H. E. Ehrhardt		25a. DATE REC'D. BY REGISTRAR Nov 12 1985		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. ADDRESS Owings Mills, Md.				

MEDICAL CERTIFICATION

332083

RECEIVED
MAY 10 1968

No.	County	City	State	Date
101-101	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-102	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-103	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-104	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-105	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-106	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-107	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-108	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-109	Carroll County	Carroll	Ark.	Nov. 3, 1967
101-110	Carroll County	Carroll	Ark.	Nov. 3, 1967

Nov. 7, 1967
Carroll County, Ark.
Carroll, Ark.

337062

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard H. Barron			2a. DATE OF DEATH MONTH DAY YEAR Nov. 20, 1985		2b. HOUR 2:30 M	
1 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 3, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS
7a BIRTHPLACE (STATE OR FOREIGN) COUNTRY New Jersey		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard		12b KIND OF BUSINESS OR INDUSTRY Security
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN Md. Balto. Manchester			13c. STREET ADDRESS / ZIP CODE 3225 Beaver St. 21102			
14 FATHER'S NAME FIRST MIDDLE LAST John McKee Barron			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane V. Smith			
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			17b SOCIAL SECURITY NO. 214-01-6918			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal failure; Pneumonia; Diabetes mellitus; congestive heart failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Oct 31, 1985 to Nov 29, 1985 , that (I) (we) last saw the deceased alive on Nov 20, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE John S. Harshey, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD.		22e. ADDRESS 8 Anderson St. Westminster, Md. 21157				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY New Lutheran Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Manchester, Carroll, Md.						
24. FUNERAL DIRECTOR NAME H. E. Schmitt		ADDRESS Manchester, Md. 21102		25a. DATE REC'D. BY REGISTRAR NOV 25 1985		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

BP

Nov 22, 1954 New York City, New York, U.S.A.

Mr. J. Edgar Hoover, Director, FBI, Washington, D.C.

328182

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (FIRST MIDDLE LAST) Wilbur Edward Blizzard		2a. DATE OF DEATH MONTH DAY YEAR 11 26 85		2b. HOUR 9 ³⁰ P.M.	
3. SEX M.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 22 16		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 69	
7a. BIRTH PLACE (STATE OR FOREIGN) Baltimore		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Inspector		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Franklina Blizzard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Diehl		13e. STREET ADDRESS / ZIP CODE 390 N Calver Ave. 21137			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO IF UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE LAST DIGITS) WW II 213-01-9225		17. INFORMANT NAME Melvin I. Blizzard		17. ADDRESS 17 Chase St. Westminster Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatitis A</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u> <u>3 wks</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

GI Bleeding

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>85</u> , to <u>11/26</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>11/26</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Norman Goldstein M.D.</u>		DEGREE		22c. DATE SIGNED 11-27-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Goldstein		22e. ADDRESS 218 Washington Heights Med. Center Westminster Md 21157					

23a. BURIAL, CREMATION, REMOVAL (SP) Burial		23b. DATE 11-30-1985		23c. NAME OF CEMETERY OR CREMATORY Kruider's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR NAME Thomas J. Fletcher				ADDRESS Westminster Md.		25a. DATE REC'D. BY REGISTRAR DEC 2 1985	
25b. REGISTRAR'S SIGNATURE							

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Handwritten text at the bottom of the page, possibly a signature or date.

323036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNA Abasha BOWERSOX			2a. DATE OF DEATH MONTH 11 DAY 12 YEAR 85			2b. HOUR 4:13 A.					
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH MARCH DAY 4 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Seaford, Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grief's			12b. KIND OF BUSINESS OR Sewing Factory		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 19 W. Green Street 21157		
14. FATHER'S NAME FIRST Edwin MIDDLE LAST Willey			15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE LAST Watson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-01-8771			17. INFORMANT ADDRESS 432 Sycamore Ave Olive J. Long Westminster, Md. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from OCT 15 , 19 85 , to NOV 3 , 19 85 , that (I) (we) lost saw the deceased alive on NOV 8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur L. Rudolph MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/12/85		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDOLPH						22c. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-15-85		23c. NAME OF CEMETERY OR CREMATORY Krider's Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.			
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.I. ADDRESS 254 East Main Street Westminster, Md. 21157			25a. DATE REC'D. BY REGISTRAR NOV 15 1985			25b. REGISTRAR'S SIGNATURE John Krider					

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL ISAAC BOWMAN			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1985		2b. HOUR 3:17 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmaster	12b. KIND OF BUSINESS OR INDUSTRY Postal Svc.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Middleburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6119 Middleburg Rd./21768	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. C. Bowman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Flickinger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-34-2007	17. INFORMANT Genevieve Bowman		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADULT RESPIRATORY DISTRESS SYNDROME			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONITIS			1 DAY		
DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARREST 2° ASCVD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/5/85 , 19____, to 11/10/85 , 19____, that (I) (we) last saw the deceased alive on 11/10/85 , 19____, and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Howard E. Lanham, MD			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/10/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD E. LANHAM, MD		22e. ADDRESS 215 WASHINGTON HILLS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 14, 1985	23c. NAME OF CEMETERY OR CREMATORY Middleburg Methodist	23d. LOCATION CITY OR TOWN COUNTY STATE Middleburg, Carroll, Maryland		
24. FUNERAL DIRECTOR NAME Skiles Funeral Homes		136 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR NOV 15 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Pendell

Nov 10, 1982

Nov. 12, 1984

Amesbury

File

Carroll Co.

U.S.A.

Amesbury

Nov 10, 1982

Carroll Co.

Carroll Co. Amesbury

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH B. M. BRADFORD			2a. DATE OF DEATH MONTH DAY YEAR November 21, 1985		2b. HOUR 9:30 P M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Balto.		13c. CITY OR TOWN Glyndon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13624 Longnecker Rd. 21071		
14. FATHER'S NAME FIRST MIDDLE LAST F. Smith Marlow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Wheeler								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 216 30 2038		17. INFORMANT Basil B. Bradford,			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, probably DUE TO, OR AS A CONSEQUENCE OF (b) into a brain tumor. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Dox Belies survival onset											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1950 N Po 21 85						
21g. I certify that (I) (this hospital) attended the deceased from 1950 to 1985, that (I) (we) last saw the deceased alive on Nov 21, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and not from the body after death.											
22a. SIGNATURE Dr. William G. Helfrich, MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/22/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William G. Helfrich, MD			22e. ADDRESS 5006 Roland Ave., Balto., MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/23/85		23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION CITY OR TOWN COUNTY STATE Glyndon, MD				
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR NOV 22 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy may be required.

339145

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must examine the body.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) L.T. Bullock			2a DATE OF DEATH MONTH DAY YEAR 11 - 29 - 85		2b HOUR 10 p.m.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10 - 07 - 1928	6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10 CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a STATE MD	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13e STREET ADDRESS / ZIP CODE 1120 Fannie Dorsey Road 21784		
14 FATHER'S NAME FIRST MIDDLE LAST Walter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glados Keen			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243404667A		17 INFORMANT ADDRESS Mrs. Marjorie Bullock Sykesville, MD 21784	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Known triple vessel CAD & prior MI & severe PVD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.S. Kalaria		DEGREE MD		22c. DATE SIGNED 11/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.S. KALARIA		22e. ADDRESS 908 Washington Rd, Westminster			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-03-85		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD		24. FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Sykesville, MD 21784			
25a. DATE REC'D. BY REGISTRAR DEC 2 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

BP



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318170

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Susan S. Ruby Care			2a DATE OF DEATH MONTH DAY YEAR November 1 1985		2b HOUR 6:13 pm	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9 10 99		6 AGE (IN YEARS LAST BIRTHDAY) 86
7a BIRTHPLACE (STATE OR FOREIGN) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.
10 CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b KIND OF BUSINESS OR INDUSTRY Umbrella Factor		13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				
13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Rosemont Avenue 21701
14 FATHER'S NAME FIRST MIDDLE LAST John Ruby			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Easter			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-28-5900		17 INFORMANT ADDRESS Springfield Hosp. Center Sykesville MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Occlusion of Rt. Coronary Artery Ostium						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						years
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis						years
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD						years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Primary degenerative dementia, senile onset, with delusions						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from Sept. 29 , 19 82 , to Nov. 1 , 19 85 , that (I) (we) last saw the deceased alive on Nov. 1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.						
22b SIGNATURE Lourdes T. Natividad, M.D.				DEGREE MD		22c DATE SIGNED 11/1/85
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lourdes T. Natividad MD				22e ADDRESS Springfield Hosp. Center Sykesville MD.		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/5/85		23c NAME OF CEMETERY OR CREMATORY Park Heights Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Brunswick, Fred., Md.
24 FUNERAL DIRECTOR NAME Harry Haight Sykesville MD				25a DATE REC'D. BY REGISTRAR 11/2/85		25b REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



319018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Andrea D'Eugenio</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 7 1985</i>			2b. HOUR <i>3:26 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1/29/95</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.	
10. CITY OR TOWN OF DEATH <i>Sykesville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sykesville Elder Care Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Barber</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		13a. STATE <i>md.</i>					
13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>21157 819 Western Chapel Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Anthony D'Eugenio</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth UNK.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-12-0980</i>		17. INFORMANT <i>Gerardine Broccolino</i>		ADDRESS <i>Tel 889-1040</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF - SEVERE TEXEMA</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>OKS -</i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1983</i> , 19 <i>85</i> , to <i>11/7</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10-23</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>R. Ricci MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/8/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Ricci MD</i>				22e. ADDRESS <i>3125 BALTIMORE FINKSBURG, MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-9-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Jesus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Joseph N. Zannino Fun Home</i>				ADDRESS <i>263 South Conkling St</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1985</i>	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE REASON THEREFOR. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 5 SHOULD BE USED AS A BURIAL. TRANSFER PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVIAL.

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Christine L Dorsey											
2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR		M	
11-7		19		85				9:20		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
female		white		6 12 62		23 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
Md		USA		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		south of Old Hanover Pt. & Silver Run Roads		student		school					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		730 Washington Rd		21157	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John W. Dorsey				Helga A. Dorsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
no				n/a				John Dorsey 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyanide Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				11-7869				Subject Ingested drug			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				IN auto				South of Old Hanover Pt & Silver Run Rd, Carroll Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE			
Dennis F. Smyth, M.D.				Assistant				11-10-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md.				21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
cremation		11/12/85		Carroll Cremation		Hampstead		Carroll		Md	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
PRITTS FUNERAL HOME				11/18/85				John Davidson-Randall			

333083



William Douglas

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TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make sure that the certificate is properly filled in by the funeral director. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
James Eagle			11 5 85			10:15 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Black	3 17 15	70 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Not Known	USA		Carroll MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville	Sykesville Elder care		Truck Driver					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Md.			Beechboro Perry Point			21902		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST			FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes			1942-1944			265-05-4215 E. Duff LPN 4417 Rupp Rd M. Hers. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) VIRAL INFECTION DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from August 30, 1985, to November 5, 1985, that (I) (we) last saw the deceased alive on November 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
21g. SIGNATURE						DEGREE		22c. DATE SIGNED
Jose L. Chapulte						M.D.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Jose L. CHAPULTE						6342 Barnett Ave. SYKESVILLE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Nov. 8, 1985		Culpepper National		Culpepper, Culpeper, Virginia	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Farring Funeral Home, P.A., Aberdeen, MD, 21001-3399						11/12/85		John R. ...

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} Margaret ^{MIDDLE} E. ^{LAST} Faulkner				2a. DATE OF DEATH MONTH DAY YEAR Nov 22, 1985	
3 SEX Female				2b. HOUR 1730 M	
4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper - Maryland State		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead	
14. FATHER'S NAME ^{FIRST} Charles ^{MIDDLE} R. ^{LAST} Leight		15. MOTHER'S MAIDEN NAME ^{FIRST} Addie ^{MIDDLE} V. ^{LAST} Fowble		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-10-9255		17. INFORMANT ADDRESS Mr. A. Donald Faulkner, same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 12, 1985 to Nov 22, 1985, that (I) (we) last saw the deceased alive on Nov 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John S. Harshey, MD		DEGREE		22c. DATE SIGNED 11/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY MD.		22e. ADDRESS 8 Anchor St. Westminster, Md. 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-26-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE NOV 26 1985		25b. REGISTRAR SIGNATURE	

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert H Forsyth			2a. DATE OF DEATH MONTH DAY YEAR Nov. 5, 1985		2b. HOUR M 10 P.
3. SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 - 26 - 29		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10 CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7609 Mellon Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7609 Mellon Avenue 21784
14. FATHER'S NAME FIRST MIDDLE LAST Thomas C. Forsyth, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie McCarron			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216228825	17 INFORMANT ADDRESS Mrs. Doris A. Forsyth, Sr. Sykesville, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Catch the head of the Pancreas DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald D. Coker MD		DEGREE MD		22c. DATE SIGNED 6 Nov 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD		22e. ADDRESS 222 Washington South Indian Creek Washington MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-9-85	23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD	
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, MD 21784		25a. DATE REC'D BY REGISTRAR NOV 08 1985	25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove corroboration with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

336095

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: Leroy LAST: Freeland		2a. DATE KNOWN OF DEATH ESTIMATED MONTH: 11 DAY: 21 YEAR: 85		2b. HOUR: 11	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 4 DAY: 16 YEAR: 1939	6. AGE (IN YEARS) LAST BIRTHDAY: 46 YRS.	IF UNDER 1 YR. MONTHS: DAYS: HOURS: MIN.	IF UNDER 24 HRS. MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR COUNTY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 2876 Baltimore Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK) Construction	
13a. COUNTY Carroll		13b. CITY OR TOWN Westminster		13c. STREET ADDRESS Pook Rd. 21157	
14. FATHER'S NAME FIRST: Wilmer MIDDLE: Joseph LAST: Freeland Sr.		15. MOTHER'S MAIDEN NAME FIRST: Virginia MIDDLE: Mae LAST: Shotts		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 215-36-8290		17. INFORMANT Kenneth W. Freeland		ADDRESS 4414 Colby Rd. Pikesville Md. 21208	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to abdomen DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Richard M. Sonas MD		TITLE (SPECIFY) Deputy Medical Examiner		DATE SIGNED 21 Nov 85	
EXAMINER'S NAME (TYPE OR PRINT) Richard M. Sonas MD		ADDRESS Carroll County General Hosp			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Cremation		23b. DATE 11-20-1985		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Carroll Md		24. FUNERAL DIRECTOR NAME: Thomas J. Fletcher ADDRESS: Westminster Rd.		25a. DATE REC'D. BY REGISTRAR NOV 26 1985	
				25b. REGISTRAR'S SIGNATURE	

100

338161

FOR
STATE
REGISTRAR Ethel Belle Garber

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel Belle Garber			2a. DATE OF DEATH MONTH DAY YEAR 11 27 85			2b. HOUR 2:20 PM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 03 10 04	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS			IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Hosp & Convales. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Clothing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST LAST Albert Baker			15. MOTHER'S MAIDEN NAME FIRST LAST Mary Curfman			16. SOCIAL SECURITY NO. 216-05-2014	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			17b. SOCIAL SECURITY NO. 216-05-2014			17c. INFORMANT Mildred Anders	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			18b. SOCIAL SECURITY NO. 216-05-2014			18c. INFORMANT Mildred Anders	

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Starvation</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Cell Cancer & Metas</u>		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 0	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 0 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 0	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 0	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 0	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/02/85</u> , 19 <u>85</u> , to <u>11/27</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			

22b. SIGNATURE <u>John W. Middleton</u>	DEGREE	22c. DATE SIGNED <u>11/27/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John W. Middleton MD</u>	22e. ADDRESS <u>182 East Main Street Westminster MD</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 30, 1985	23c. NAME OF CEMETERY OR CREMATORY Grace United Ch. of Christ	23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, MD
24. FUNERAL DIRECTOR NAME Skiles Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 02 1985	
25b. REGISTRAR'S SIGNATURE <u>John W. Middleton</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove carbon pages, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

338151

File

10/10/51

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325064

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1- STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CURTIS CHARLES Glass										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 11 85
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Apr. 14, 1906	6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 11 1985	2d. HOUR 10			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Cement		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6065 Taneytown Pike/21787		
14. FATHER'S NAME FIRST MIDDLE LAST Charley M. Glass				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Livesay						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-12-8375		17. INFORMANT Sally Glass				
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Complicated by Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Burial causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Richard A. Jones MD				TITLE (SPECIFY) M.D. Deputy Medical Examiner		DATE SIGNED 11 Nov 85				
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones MD				ADDRESS Carroll County General Hosp.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland				
24. FUNERAL DIRECTOR NAME Skiles Funeral Homes				126 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D BY REGISTRAR NOV 15 1985				
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

BP

DHMH-17
(VR A15 ME (5))
15M 7/77

SECRET

UNITED STATES

Department of Defense

Washington, D.C.

Office of the Secretary of Defense

Attention: Mr. [Name]

Subject: [Topic]

Date: [Date]



Approved: [Signature]
Special Agent in Charge, FBI
[Date]

322146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Mahlon Grimm			2a. DATE OF DEATH MONTH DAY YEAR 11 12 85			2b. HOUR 11 27 M			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 01 1889		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13e. STREET ADDRESS / ZIP CODE 7439 Springfield Avenue 21784			
14. FATHER'S NAME FIRST MIDDLE LAST William Scott Grimm				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Paynter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 14 9126		17. INFORMANT ADDRESS Joseph Grimm - Lutherville, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED	
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS		IMMED	
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CORONARY HEART DISEASE 11 YEARS			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **ESSENTIAL HYPERTENSION**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/12 19 85 to 11/12 19 85 , that (I) (we) last saw the deceased alive on 11/12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vincent Fiocco				DEGREE MD		22c. DATE SIGNED 11/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent Fiocco				22e. ADDRESS Westminster, Md. 21157			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11 - 15 - 85		23c. NAME OF CEMETERY OR CREMATORY Brandenburg Church		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Sykesville, MD 21784				25a. DATE REC'D. BY REGISTRAR NOV 14 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

30114 MONTICO 202

11 - 21 - 11

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. Page 3 should be filed with the funeral home. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this should be noted on the back of page 1.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leonard Bernard Grote			2a. DATE OF DEATH MONTH DAY YEAR Nov. 7, 1985			2b. HOUR 5:46 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		# UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard		12b. KIND OF BUSINESS OR INDUSTRY Menu. Co.	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1011 Highfield Dr. 21074	
14. FATHER'S NAME FIRST MIDDLE LAST F. Clarence Grote				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Preston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-03-0237		17. INFORMANT Ethel Grote		ADDRESS 1011 Highfield Dr. Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Vascular Disease DUE TO, OR AS A CONSEQUENCE OF Pressure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/5 9:12 PM 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Manchester, Md.				
22a. I certify that (1) (this hospital) attended the deceased from 4/5 , 19 83 , to 11/7 , 19 85 , that (1) (two) lost saw the deceased alive on 9/12/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.									
22b. SIGNATURE W H Foard MD			DEGREE			22c. DATE SIGNED 11/7/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Foard MD			22e. ADDRESS 3223 Main St Box E Manchester, Md 21102						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gar. Finksburg, Carroll, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME H. E. Echhardt			ADDRESS Manchester, Md.			25. DATE REG. BY REGISTRAR NOV 13 1986			
25. REGISTRAR'S SIGNATURE J. A. Anderson									

BP

317076

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 5 5

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER SAFFORD HAMMOND			2a DATE OF DEATH MONTH DAY YEAR 11 02 85		2b HOUR M AM	
3 SEX MALE		4 RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 10 12 01		
6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.				
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1706 Sykesville Rd.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory		
12b KIND OF BUSINESS OR INDUSTRY Shoe factory		13a STREET ADDRESS / ZIP CODE 1706 Sykesville Rd. 21157				
13a STATE MD.		13b COUNTY CARROLL		13c CITY OR TOWN WESTMINSTER		
14 FATHER'S NAME FIRST MIDDLE LAST Walter Hammond		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Hammond				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) na		17 INFORMANT ADDRESS 21157		
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old age</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u>						
19a DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				
21b. TIME OF INJURY A.M. MONTH DAY YEAR <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>N/A</u>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>		
22a I certify that (I) (this hospital) attended the deceased from <u>10/14/85</u> to <u>11/4/85</u> that (I) (we) last saw the deceased alive on <u>11/4/85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>John W. Middleton</u> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>11/4/85</u>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John W. Middleton</u>		22e ADDRESS <u>182 East Main Street Westminster MD</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/85		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		
23d LOCATION CITY OR TOWN COUNTY STATE Smallwood Carroll MD.		24 FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD				
25a. DATE REC'D. BY REGISTRAR NOV 6 1985		25b. REGISTRAR'S SIGNATURE <u>John W. Middleton</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked other than 18, state any injury, or other traumatic event, or medical condition that may have contributed to the death.

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EX-111

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINCIPAL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES LEONARD HANSEN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11 24 85	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12/31/27	6. AGE (IN YEARS) YEARS MONTHS DAYS 57	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 24 1985		2d. HOUR 11			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL					
10. CITY OR TOWN OF DEATH FINKSBURG		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FINKSBURG 2801 HANSEN LANE MD. 21048				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING HOURS) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN MARYLAND CARROLL FINKSBURG										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. HANSEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MAY JUSTICE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. KOREA 212-26-6277		17. INFORMANT NAME ADDRESS HOWARD F. HANSEN BEDFORD, PA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries DUE TO, OR AS A CONSEQUENCE OF (b) Falling Tree DUE TO, OR AS A CONSEQUENCE OF (c) 916 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Robert A. Meyer				TIME (SPECIFY) M.D. 12/24/85				DATE SIGNED 24/10/85			
EXAMINER'S NAME (TYPE OR PRINT) Robert A. Meyer				ADDRESS 91 Willis St Westminster, MD							
23. BURIAL, CREMATION, REMOVAL (a) (b) (c) BURIAL				23b. DATE Nov. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY SANDY MOUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FINKSBURG CARROLL MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Meyer 91 Willis St Westminster, MD				25. DATE REC'D. BY REGISTRAR 12/24/85		26. REGISTRAR'S SIGNATURE John D. ...					

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CHANDLER, ALAN W.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 5 7

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Shirley May Harris			2a. DATE OF DEATH MONTH DAY YEAR 11 23 85			2b. HOUR 11 45 PM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10 23 34		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cleveland, Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter B. Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-4517		17. INFORMANT ADDRESS Joseph O. Harris 4150 Littlestown Pike			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GI Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Failure & Varices</u> months DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic alcoholism</u> years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hr
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (the hospital) attended the deceased from 11/23, 1985, to 11/23, 1985, that (I) (we) last saw the deceased alive on 11/23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE <u>John E. Steers</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/23/85</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers		22e. ADDRESS 222 Washington Hts, Westminster Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-27-85		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Run Carroll Md.	
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24. FUNERAL DIRECTOR <u>Thomas D. Fletcher & Son</u>		25a. DATE REC'D. BY REGISTRAR DEC 2 1985		25b. REGISTRAR'S SIGNATURE	
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MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JONAS ALFRED HELTEBRIDLE				11-6-85				1033 ^{PM}
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 25 1909		6. AGE (IN YEARS (LAST BIRTHDAY)) 76		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.				
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Taneytown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 435 E. Baltimore St./21787				
14. FATHER'S NAME FIRST MIDDLE LAST Jonas E. Heltebridle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura A. Stuller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-03-4648		17. INFORMANT Eva Hope Heltebridle 435 E. Baltimore St. Taneytown, MD 21787				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11-6-85 to 11-6-85 that (I) (we) lost saw the deceased alive on 11-6-85 above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE N. RASPARA MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-6-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RASPARA MD.				22e. ADDRESS 224 Washington fth. Westminster md 21787				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Grace U.C.C. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Skiles Funeral Homes 136 E. Baltimore St. Taneytown, MD 21787				25a. DATE REC'D. BY REGISTRAR NOV. 12 1985		25b. REGISTRAR'S SIGNATURE J. A. ...		

BP

330085

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. This page remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED RUTH HELWIG			2a. DATE OF DEATH MONTH DAY YEAR Nov 18/1985		2b. HOUR 19 50 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01/27/08		6. AGE (IN YEARS LAST BIRTHDAY) 77
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARROLL COUNTY GENERAL			12a. USUAL OCCUPATION HOUSEWIFE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE FREDERICK		13c. CITY OR TOWN NEW WINDSOR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 1519 OAK ORCHARD RD. 21736
14. FATHER'S NAME FIRST MIDDLE LAST HARVEY REESE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GULA BARNES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-76-8786		17. INFORMANT ADDRESS OLIVIA H. DEVILBISS 2827 RIDGE RD. WESTMINSTER, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Acute bronchitis</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 12</u> , 19 <u>85</u> , to <u>Nov 18</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Nov 18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>John S. Harshey, MD</u>		DEGREE		22c. DATE SIGNED <u>11/18/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN S. HARSHEY, MD.</u>		22e. ADDRESS <u>8 Anchor St. Westminster, Md. 21157</u>				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 11/21/85		23c. NAME OF CEMETERY OR CREMATORY LINGANORE CEMETERY		
23d. LOCATION UNTONVILLE FRED. MD						
24. FUNERAL DIRECTOR D. D. HARTZLER		25a. DATE REC'D. BY REGISTRAR NOV 22 1985		25b. REGISTRAR'S SIGNATURE <u>John S. Harshey, MD</u>		

BP

330052



319083

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 & 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE Henry			LAST Hoff			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 11			DAY 7			YEAR 1985			2b. HOUR M											
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 14 28			6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.			IF UNDER 1 YR MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 7 1985			2d. HOUR M																			
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.																							
10. CITY OR TOWN OF DEATH near New Windsor				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2300 Marston Road								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Mink-Pork																			
13a. STATE Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN New Windsor				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2516 Marston Rd./21776																					
14. FATHER'S NAME FIRST MIDDLE LAST J. Earle Hoff						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lonie Lambert						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1955-56						16b. SOCIAL SECURITY NO. 218-24-7697						17. INFORMANT Arlene Hoff						ADDRESS New Windsor, Md 21776 2516 Marston Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>With hypertension</i> (c) <i>Arteriosclerotic Cardiovascular Disease</i>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																			
ACTUAL SIGNATURE <i>Richard D. Hartzler</i>						TITLE (SPECIFY) M.D.						MEDICAL EXAMINER						DATE SIGNED 7 Nov 85																	
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS Carroll County, Bewersdorf, Pa.																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 11/10/85						23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE New Windsor Carroll Md.																	
24. FUNERAL DIRECTOR D.D.E. Hartzler & Sons												25a. DATE REC'D. BY REGISTRAR NOV 13 1985												25b. REGISTRAR'S SIGNATURE <i>Richard D. Hartzler</i>											

1800

1800

[Faint, illegible handwriting throughout the page]

333067

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, WORKING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Christopher Daniel Ifert							2a. DATE KNOWN OF DEATH ESTIMATED 11 20 1985		7b. HOUR 7 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 2 - DAY 24 - YEAR 04	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 11 20 1985		7d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1133 Liberty Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1133 Liberty Road 21784		
14. FATHER'S NAME FIRST Daniel MIDDLE Christopher LAST Ifert				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST Ridenout						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 36 1833		17. INFORMANT ADDRESS Margaret Ifert Sykesville, MD 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Guns Shot Wound DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held them until burial, cremation, or other disposition. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Nonnatural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Richard A. Jones			TITLE (SPECIFY) Deputy		MEDICAL EXAMINER Carroll General Hosp, Westminster			DATE SIGNED 20 Nov 85		
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones			ADDRESS Carroll General Hosp, Westminster							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-24-85		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD		
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville, MD 21784							
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE NOV 22 1985							

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

13-40-42-2 5414

10. 11. 2000

3. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

921 OF 913

22-15-11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

317168

1. DECEASED NAME (TYPE OR PRINT) Pearl Samuel Johnson			2a. DATE OF DEATH MONTH 11 DAY 7 YEAR 85			2b. HOUR 0730 M								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 22 YEAR 1887		6. AGE (IN YEARS LAST BIRTHDAY) 97		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Middleburg, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21 Pleasant Valley Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR College					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21 Pleasant Valley Rd. 21157		
14. FATHER'S NAME FIRST William MIDDLE P. LAST Johnson						15. MOTHER'S MAIDEN NAME FIRST May MIDDLE A. LAST Sixx								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-05-7564			17. INFORMANT 196 Pennsylvania Ave Sterling L. Carr Westminster, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-15-1985 to 11-7-1985 , that (I) (we) last saw the deceased alive on 10-24-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE CHITRACHEDU NAGANNA MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-7-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA						22e. ADDRESS 700 A pole Rd. Westminster, MD 21157								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-9-85			23c. NAME OF CEMETERY OR CREMATORY Meadow Branch			23d. LOCATION CITY OR TOWN Westminster COUNTY Carroll STATE Md.					
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son 254 East Main Street Westminster, Md. 21157						25. DATE REC'D. BY REGISTRAR NOV 08 1985			25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

202-204-1111

CHIEF



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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		11-20-85		1159 M	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		12-1-1901		84 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Carroll County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County Gen. Hospital		Salesman		Dpt. Store	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Howard		Brookeville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13e. STREET ADDRESS / ZIP CODE			
Darius W. Burns		Camsadel Haines		3701 Damascus Road		20833	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
NO		329 18 8471		Mildred Simms		Brookeville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>2287</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-19-85</u> , 19 <u>85</u> , to <u>11-20-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11-20-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>CHITRACHEDU NAG ANNA</u>						11/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
CHITRACHEDU NAG ANNA		700 A road Rd Westminster MD 21157		Burial		11-23-85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Jennings Chapel Cemet		Woodbine Howard MD		Harry W. Haight Sykesville, MD 21784		NOV 22 1985	
						25b. REGISTRAR'S SIGNATURE	
						Julia Davidson-Randall	

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318055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 6 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIA Maud KRESS			2a. DATE OF DEATH MONTH DAY YEAR 11 4 85			2b. HOUR 1:20 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 12 1885		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HWF	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Strover		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 218-54-0098		17. INFORMANT Miss Mary Kress, Hampstead, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 DAY

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from NOV. 3, 1985, to NOV. 4, 1985, that (I) (we) lost saw the deceased alive on NOV 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ARTHUR L. RUDO, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDO, MD				22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-7-85		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE New Windsor Carroll Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				25a. DATE REC'D BY REGISTRAR NOV 12 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wm. J. ...



30% COTTON FIBER

Wm. J. ...

Wm. J. ...

AG

Wm. J. ...

Wm. J. ...

Wm. J. ...

Wm. J. ...

318095

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JULIA S KULACKI					2a. DATE OF DEATH MONTH DAY YEAR 11 3 85			2b. HOUR 3 38 P M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 20 10		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY, MD.			
10 CITY OR TOWN OF DEATH TANEYTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4931 FEESEER RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE MARYLAND		13b. CITY OR TOWN CARROLL		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4931 FEESEER RD 21787			
14 FATHER'S NAME FIRST MIDDLE LAST Stanley Sherry					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Branish				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-28-4052		17 INFORMANT Walter C. Kulacki		4931 Feezer Road Taneytown, MD 21787			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLOBLASTOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 11/15, 1985, to 11/3, 1985, that (b) (we) last saw the deceased alive on 10/16, 1985, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm. R. LINTHICUM, MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/4/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS TANEYTOWN, MARYLAND 21787					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 3, 1985		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland			
24 FUNERAL DIRECTOR NAME Skiles Funeral Homes		136 E. Baltimore St. ADDRESS Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

BP.

312005



UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20007

319044

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rev. Dr. Theodore S. Ledbetter			2a. DATE OF DEATH MONTH DAY YEAR 11 11 85			2b. HOUR 1050 M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1-15-10		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Golaid, Tex		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County, MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Minister		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Mont Silver Spring				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 828 Violet Place 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Ceasar Socaties Ledbetter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Clemens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 042-30-1205		17. INFORMANT ADDRESS Mrs. Orelia W. Ledbetter/wife/same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Acute respiratory failure. DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: FX LEFT HIP							
19a. DATE OF OPERATION 11-8-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FX LEFT HIP		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11-4-85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fell + injured @ hip			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) SPRINGFIELD HOSP.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE SYKESVILLE CARROLL MD			
22a. I certify that (I) (this hospital) attended the deceased from 11-7-85 to 11-11-85, that (I) (we) last saw the deceased alive on 11-11-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Muenene		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NOEL S. GRESSIEUX		22e. ADDRESS 216 WASHINGTON HEIGHTS WESTMINSTER MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-14-85		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C.				25a. DATE REC'D. BY REGISTRAR NOV 13 1985			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE R.			LAST Lilly			2a. DATE KNOWN OF ESTI. DEATH MATED XX 11-8 19 85			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-3-1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 11-8 19 85			2d. HOUR 2:30 p. M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD							
10. CITY OR TOWN OF DEATH Westminster				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2830 Old Tawneytown Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret - Civil Service Employee				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 2840 Old Tawneytown Rd. 21157			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lilly										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Long									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --				17. INFORMANT Westminster ADDRESS MD 21157 Mrs. Jean Creamer 2840 Old Tawneytown Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 11-9-85							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 11-10-85				23c. NAME OF CEMETERY OR CREMATORY Westview Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD							
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133										25a. DATE REC'D. BY REGISTRAR NOV 12 1985				25b. REGISTRAR'S SIGNATURE					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

118014



331037

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 FOR
1- STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
LORRAINE		E.		LONG				11		23		19		85		A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	11/8/64		21 YRS.						11		23		19		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Hanover Pa.		USA				Carroll County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Sykesville		Morgan Run Bridge		St. Highway Dept.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Carroll		Finksburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		1900 Carrollton Rd.		21048							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Eldon Denton Long Sr.		Doris J. Harris															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		215-88-9276		Ms. Doris J. Long		Finksburg, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
8/20		Multiple injuries		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
7		11-23-1985		Driver of auto/auto collision.													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
bridge		Morgan Run Bridge		Carroll		MD											
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		11-23-85											
Ann M. Dixon, M.D.		M.D. Assistant		MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., MD		21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		11/26/85		Evergreen Memorial		Finksburg, Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Eline Funeral Home		Reisterstown, Md.		NOV 25 1985													

331035



2016 COLTON FIBER

DAVID M. VAN FLETER

— B. D. Smith

315045

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

31569

1. DECEASED NAME (TYPE OR PRINT) ELSIE W. MARSEN Himer			2a. DATE OF DEATH MONTH DAY YEAR 11-25-85			2b. HOUR 5:30			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 12 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURSING				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	

13a. STATE MD.			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 138 WESTMINSTER AVE 21157	
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14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN UNKNOWN		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) UNKNOWN		17. INFORMANT ADDRESS MRS CLIFTON MYERS WESTMINSTER MD	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COLONIC CARCINOMA W/EXTENSIVE DUE TO, OR AS A CONSEQUENCE OF (c) METASTASES			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE John W. Middleton M.D.		DEGREE		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Middleton MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

22d. ADDRESS 182 East Main Street Westminster MD	
--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-27-85		23c. NAME OF CEMETERY OR CREMATORY DEER PARK		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER CARROLL MD	
---	--	------------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR PRITTS FUNERAL HOME WESTMINSTER, MD		25a. DATE REC'D. BY REGISTRAR DEC 05 1985		25b. REGISTRAR'S SIGNATURE John W. Middleton	
--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Page 4 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2000 2001 2002

1900

316022

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT - CREMATION - REMOVAL - DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
Wayne			Leonard			Miller					
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		Cauc.		12 22 29		55		MONTHS		DAYS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll County General Hospital			Factory			Worth. Pump		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD			Carroll			Westminster			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Paul			Daniel			Miller			Effie		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Freda R. Miller			13e			19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20. AUTOPSY?		
no			na			21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY		
						21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21d. INJURY OCCURRED		
						21e. LOCATION			21f. LOCATION		
						21g. CITY OR TOWN			21h. COUNTY		
						21i. STATE			21j. STATE		
						21k. DATE			21l. DATE		
						21m. TIME			21n. TIME		
						21o. PLACE			21p. PLACE		
						21q. STREET			21r. STREET		
						21s. FACTORY			21t. FACTORY		
						21u. FARM			21v. FARM		
						21w. ETC.			21x. ETC.		
						21y. DATE			21z. DATE		
						21aa. TIME			21ab. TIME		
						21ac. PLACE			21ad. PLACE		
						21ae. STREET			21af. STREET		
						21ag. CITY OR TOWN			21ah. CITY OR TOWN		
						21ai. COUNTY			21aj. COUNTY		
						21ak. STATE			21al. STATE		
						21am. DATE			21an. DATE		
						21ao. TIME			21ap. TIME		
						21aq. PLACE			21ar. PLACE		
						21as. STREET			21at. STREET		
						21au. FACTORY			21av. FACTORY		
						21aw. FARM			21ax. FARM		
						21ay. ETC.			21az. ETC.		
						21ba. DATE			21bb. DATE		
						21bc. TIME			21bd. TIME		
						21be. PLACE			21bf. PLACE		
						21bg. STREET			21bh. STREET		
						21bi. CITY OR TOWN			21bj. CITY OR TOWN		
						21bk. COUNTY			21bl. COUNTY		
						21bm. STATE			21bn. STATE		
						21bo. DATE			21bp. DATE		
						21bq. TIME			21br. TIME		
						21bs. PLACE			21bt. PLACE		
						21bu. STREET			21bv. STREET		
						21bw. FACTORY			21bx. FACTORY		
						21by. FARM			21bz. FARM		
						21ca. ETC.			21cb. ETC.		
						21cc. DATE			21cd. DATE		
						21ce. TIME			21cf. TIME		
						21cg. PLACE			21ch. PLACE		
						21ci. STREET			21cj. STREET		
						21ck. CITY OR TOWN			21cl. CITY OR TOWN		
						21cm. COUNTY			21cn. COUNTY		
						21co. STATE			21cp. STATE		
						21cq. DATE			21cr. DATE		
						21cs. TIME			21ct. TIME		
						21cu. PLACE			21cv. PLACE		
						21cw. STREET			21cx. STREET		
						21cy. FACTORY			21cz. FACTORY		
						21da. FARM			21db. FARM		
						21dc. ETC.			21dd. ETC.		
						21de. DATE			21df. DATE		
						21dg. TIME			21dh. TIME		
						21di. PLACE			21dj. PLACE		
						21dk. STREET			21dl. STREET		
						21dm. CITY OR TOWN			21dn. CITY OR TOWN		
						21do. COUNTY			21dp. COUNTY		
						21dq. STATE			21dr. STATE		
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						21du. COUNTY			21dv. COUNTY		
						21de. STATE			21df. STATE		
						21dg. DATE			21dh. DATE		
						21di. TIME					

316003

ORIGINAL

NOTICE

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317094

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and consistently filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mr. John W. Minick			2a. DATE OF DEATH MONTH DAY YEAR November 6 1985		2b. HOUR 1145 M
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 4 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10 CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountical Eng	12b. KIND OF BUSINESS OR INDUSTRY John H Hampshir	
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 418 Baldwin Park Dr. 21157
14. FATHER'S NAME FIRST MIDDLE LAST John W. Minick Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Hamburg		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 218-09-2904		17. MRS. PAULINE D. MINICK ADDRESS 418 Baldwin Park Dr. Westminster Maryland 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANASARCA DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SQUAMOUS CARCINOMA OF PROSTATE & TRANSITION CARCINOMA BLADDER					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 85 , to 11/6 , 19 85 , that (I) (we) last saw the deceased alive on 11/6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard G. Laniham, MD		DEGREE MD		22c. DATE SIGNED 11/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD G. LANIHAM, MD		22e. ADDRESS 215 WASHINGTON APTS WESTMINSTER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-9-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland		24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133			
25a. DATE REC'D. BY REGISTRAR NOV 08 1985		25b. REGISTRAR'S SIGNATURE John H. Hampshir			

Info	Organization	Address	Phone
Wardens	Ill	Carroll County	
Inspector	Carroll County Sheriff's Dept	Carroll County, Ill	John W. Hefner
Inspector	Carroll	Wendover	2177
John W. Hefner		148 W. Main St.	2177
Ill	217-207	148 W. Main St.	2177

11-2-71
Illinois State Police
Carroll County Sheriff's Dept
2177

325093

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN H. Herbert MOSER			2a. DATE OF DEATH MONTH DAY YEAR 11-9-85			2b. HOUR 0400 PM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 65 Ralph Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Flooring		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 65 Ralph Street/21157	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Moser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Hollenberry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 220-18-1209		17. INFORMANT 529 Geneva Drive Claude H. Moser Westminster, MD 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-8-1985</u> , to <u>11-9-1985</u> , that (I) (we) last saw the deceased alive on <u>11-8-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Chitra Chetty</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-11-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRA CHETTY N AGANNA					22e. ADDRESS 700 A poole Rd Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Keysville, Carroll, Maryland		
24. FUNERAL DIRECTOR NAME Skiles Funeral Homes			136 E. Baltimore St. ADDRESS Taneytown, MD 21787			25a. DATE REC'D. BY REGISTRAR NOV 15 1985				
25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The separate form for carbon copies, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

310032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NELL G. MYERS			2a. DATE OF DEATH MONTH DAY YEAR 11/1/85			2b. HOUR 3:40 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/17/96		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
10 CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sykesville Eldercare		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Secretary	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FRANK GUINN		15. MOTHER'S MAIDEN NAME LOU SEIBERT		13e. STREET ADDRESS 7312 First Ave., 21784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 291 20 2488		17 INFORMANT ADDRESS Mrs Howard Rohrer 2530 Marriottsville RD 21104			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.H.F. DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/15 , 19 84 , to 11/1 , 19 85 , that (I) (we) last saw the deceased alive on 9/23/85 , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jose L Chappelle		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE L CHAPPELLE		22e. ADDRESS 6342 Barnett Ave. SYKESVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Md.	
24 FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home				25a. DATE REC'D BY REGISTRAR NOV 04 1985			
25b. REGISTRAR'S SIGNATURE [Signature]							

310032



338004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Viola May Myers			2a. DATE OF DEATH MONTH DAY YEAR 11/23/85			2b. HOUR 8:30 M				
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1 2 10		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.				
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing fact.		12b. KIND OF BUSINESS OR INDUSTRY Sewing fact.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 641-B Hughes Shop Rd. 21157	
14 FATHER'S NAME FIRST MIDDLE LAST William Franklin Stair, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna May Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17 INFORMANT Gladys Harman		ADDRESS 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Renal & Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>ASCUD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION /			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED /			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 10/10/85 to 11/23/85, that (I) (we) last saw the deceased alive on 11/22/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John W. Middleton MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Middleton MD			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/26/85		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD			
24 FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD			412 Washington Road			25a. DATE REC'D. BY REGISTRAR NOV 29 1985		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2-8-00

30% COMBINATION

WATER



NOTES & RECORDS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mr. Frank J. Nicolette			2a. DATE OF DEATH MONTH DAY YEAR November 19 1985			2b. HOUR 2:45 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 13 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired from		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4612 London Bridge Rd. 21784	
14. FATHER'S NAME FIRST MIDDLE LAST John Nicolette				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Lopez Messina					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WM2 233-18-6161		17. IN BALTIMORE CITY OR COUNTY OF DEATH Mrs. Jenna Nicolette ADDRESS 4612 London Bridge Rd. Sykesville Maryland 21784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GLIOBLASTOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE Frank J. Nicolette M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED	
27d. PHYSICIAN'S NAME (TYPE OR PRINT)				27e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-23-85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Rosedale Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D BY REGISTRAR NOV 22 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

318175

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MELROSE OSBORNE			2a. DATE OF DEATH MONTH DAY YEAR 11 - 9 - 85		2b. HOUR MIN. 6:55 A					
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 29 - 21		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 64		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRHAVEN				12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS OR WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE GA.			13b. COUNTY DeKalb		13c. CITY OR TOWN DECATUR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SCOTT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BAXTER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 253-74-1728			17. INFORMANT ANN McCABE			ADDRESS 7200 THIRD AVE. SYKESVILLE, MD 21784				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Supranuclear Palsy DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) partial - Brain only										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 81 , to 11/9 , 19 85 , that (I) (we) last saw the deceased alive on 11-9 , 19 85 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Patrick A. Turnes, MD						22c. DATE SIGNED 11/9/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK A TURNES, MD						22e. ADDRESS 7200 THIRD AVE SYKESVILLE, MD 21784				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-15-85		23c. NAME OF CEMETERY OR CREMATORY Balti. Nat. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR NOV 12 1985		25b. REGISTRAR'S SIGNATURE		

1512



337148

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY EDNA OWENS				NOVEMBER 22 1985 6 45 P.M.			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 17 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TANEYTOWN CARROLL MD.	
10. CITY OR TOWN OF DEATH TANEYTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 28A E BALT ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY CARROLL		13c. CITY OR TOWN TANEYTOWN	
14. FATHER'S NAME FIRST MIDDLE LAST REGINALD C. STONER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA PEELING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-07-8501		17. INFORMANT ADDRESS LEON B. OWENS HUSBAND 28A BALTIMORE ST. TANEYTOWN, MD 21787	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (my hospital) attended the deceased from AUGUST 85 to NOV. 22 85, that I saw the deceased alive on NOV 22 85, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)							
22b. SIGNATURE Daniel I. Welliver M.D.				DEGREE M.D.		22c. DATE SIGNED 11/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD				22e. ADDRESS 210 WASHINGTON HEIGHTS WESTMINSTER MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE NOV. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM		23d. LOCATION (CITY OR TOWN COUNTY) WESTMINSTER CARROLL MD.	
24. FUNERAL DIRECTOR Robert A. Myers 91 Willis St. WESTMINSTER MD 21157				25a. DATE REC'D. BY REGISTRAR NOV 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000TH ELMA OWENS
FEMALE WHITE OCT 17 1918
MAYLAND UNITED STATES
SPRINGTOWN 284 E MAIN ST.
SECRETARY

MAYLAND CANADA SPRINGTOWN
284 E MAIN ST FIRST
RECEIVED C. STUBBS
FEMA
LEONARD OWENS
SPRINGTOWN
CANNON OF LAW
10 MONTHS



we have 22 of
James I. Welliver M.D.
JAMES I. WELLIVER M.D.
WESTMINSTER M.D.
11/25/52
we have 22 of
James I. Welliver M.D.
JAMES I. WELLIVER M.D.
WESTMINSTER M.D.
11/25/52

333158

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 7 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cora Virginia Perish			2a DATE OF DEATH MONTH DAY YEAR 11 23 85			2b HOUR 0040 M					
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 13, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Reisterstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 344 Leyton Road 21136		
14 FATHER'S NAME FIRST MIDDLE LAST Howard E verett Allen				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vira Gibson Howard							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 183-16-6687		17 INFORMANT Vira M. Hopwood					344 Leyton Road, Reisterstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA - RIGHT LOWER LOBE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS YEARS											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a OSTEOPOROSIS											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 11/22, 1985 , to 11/23, 1985 , that (I) (we) last saw the deceased alive on 11/23, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Vincent J. Fiocco					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/23/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco					22e ADDRESS Carroll Co. Gen. Hospital, Westminster, Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Nov. 25, 1985		23c NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.				
24 FUNERAL DIRECTOR NAME ADDRESS R. E. Ehrhardt Owings Mills, Md.					25a DATE REC'D. BY REGISTRAR NOV 28 1985		25b REGISTRAR'S SIGNATURE John E. Fisher				

BP

DMMH - 16 60M 7/B4
(VRA 15, 4)

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0290-31-231

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• ADP relative

330034

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James A Pickett			2a. DATE OF DEATH MONTH DAY YEAR 11 14 85			2b. HOUR 0224 M						
3 SEX M		4 RACE Cm		5. DATE OF BIRTH MONTH DAY YEAR 4 10 34		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.						
10. CITY OR TOWN OF DEATH Westminster, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp. Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4538 Louisville Rd. 21048			
14. FATHER'S NAME FIRST MIDDLE LAST Herschel W. Pickett, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris R. Welsh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-32-2522		17. INFORMANT ADDRESS Alice M. Pickett, Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure, Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca of Pleura of lung</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 9 mo's 2 years 9 mo's		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the Registrar) attended the deceased from <u>Feb</u> , 19 <u>83</u> to <u>14 Nov</u> , 19 <u>85</u> , that (I) <u>am</u> lost saw the deceased alive on <u>15 Nov</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Donald D. Coker</u>						DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 14 Nov 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD						22e. ADDRESS 222 Washington Heights Medical Center Westminster, Md 21157						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-17-1985		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION CITY OR TOWN COUNTY STATE Winfield, Carroll, Md.				
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR NOV 19 1985			25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

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2001-2002-11

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340035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 8 0

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MERLE LEWIS POFFENBERGER			2a. DATE OF DEATH MONTH DAY YEAR 11/29/85		2b. HOUR 7:30 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5/6/11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH SYKESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4318 CHERRY TREE LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LPN	12b. KIND OF BUSINESS OR INDUSTRY STATE HOSP	
13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Lawrenve Poffenberger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esta Mary Long		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-2733		17. INFORMANT ADDRESS 4318 Cherry Tree Lane John J. Poffenberger, Sykesville, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 YEARS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT 19 82 to NOV 85 , that (I) (we) last saw the deceased alive on NOV 29 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Daniel I. Welliver MD DEGREE MD		22c. DATE SIGNED 11/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 12-2-85	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash, Co., Md.
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR DEC 4 1985 REGISTRAR'S SIGNATURE	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it shall be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MELODY BEAN, R. F. F. 1952
 Mrs. E. J. Bean, R. F. F. 1952
 MARY ANN BEAN, R. F. F. 1952
 SYLVIA BEAN, R. F. F. 1952

318 Cherry Tree Lane	Knoxville	Carroll	DeKalb	Lincoln	DeKalb	DeKalb	DeKalb
318 Cherry Tree Lane	Knoxville	Carroll	DeKalb	Lincoln	DeKalb	DeKalb	DeKalb

217-10-2735

1952-1953

12-2-52

323045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Julia Agnes Reisberg			2a DATE OF DEATH MONTH DAY YEAR Nov. 13, 1985			2b HOUR 10 p. M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1922		6 AGE (IN YEARS (LAST BIRTHDAY)) 63		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10 CITY OR TOWN OF DEATH Westminster		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE CITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY (None)	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY Carroll		13c CITY OR TOWN Finksburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3412 Niner Rd. 21048	
14 FATHER'S NAME FIRST MIDDLE LAST John Charles Ross				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Turnbaugh					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 216-82-2561		17 INFORMANT 3412 Niner Rd., Roland H. Reisberg Finksburg, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Respiratory failure*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*Several days*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Metastatic breast cancer**7 yrs.*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1982 to Nov 13, 1985 , that (I) (we) last saw the deceased alive on Nov 11, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b SIGNATURE <i>Paul Chang, MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 11/15/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Chang, MD</i>				22e ADDRESS <i>5601 Loch Raven Blvd, Suite 107, Baltimore, Md. 21239</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 18, 1982		23c NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.	
24 FUNERAL DIRECTOR NAME <i>H. J. Schaubert</i>				25a DATE REC'D. BY REGISTRAR NOV 15 1985		25b REGISTRAR'S SIGNATURE <i>W. J. Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is marked, item 18 is necessary injury, or other traumatic event, the medical examiner must be notified at once.

Nov. 13, 1982 10:00

Feb. 2, 1982

Carroll County

Carroll County, Md. Hospital

Westminster

1982
1982

Carroll
Hospitals

1982

John

1982
1982

1982

1982

1982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALVIN J SCHMIDT			2a. DATE OF DEATH MONTH DAY YEAR 11-24-85			2b. HOUR 7 ²⁵ P.M.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 4 16		6 AGE (IN YEARS LAST BIRTHDAY) 69		6 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYKESVILLE ELDERCARE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STATE ROAD EMPLOYEE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY CARROLL		13c. CITY OR TOWN MANCHESTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2847 EGBVALE RD 21102	
14 FATHER'S NAME FIRST MIDDLE LAST Alvin Schmidt				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Kraft					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) 1934-1936		17 INFORMANT Margaret M. Janner		ADDRESS 130 Skerring Ct CATONSVILLE MD 21022			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.H.F. DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to November 24, 1985, that (I) (we) last saw the deceased alive on November 23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did) (I did not) view the body after death.									
22b. SIGNATURE Jose L. Chapulle				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose L. CHAPULLE				22e. ADDRESS 6342 Barnett Ave. SYKESVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-25-85		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24 FUNERAL DIRECTOR NAME Eline Funeral Home				ADDRESS 934 S. main St. Hampstead Md 21074		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 6 1985 J. A. Davidson-Randall			

MEDICAL CERTIFICATION

31006

100-10100-6002

100-10100-6002



331024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph Francis Sinnott			2a. DATE OF DEATH MONTH DAY YEAR 11-21-85			2b. HOUR 4:36 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 26 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Sylarville	13e. STREET ADDRESS / ZIP CODE 7309 Second Ave. Sylarville Md 21784				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Sinnott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary O'Connell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-82-4446		17. INFORMANT Katherine S. Ingle ADDRESS 1220 Carrollyn Dr. Westminster Md 21157			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO-PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

ESOPHAGIAL CANCER & RT. PLEURAL EFFUSION

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-14 , 19 85 , to 11-21 , 19 85 , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Impara MD				DEGREE MD		22c. DATE SIGNED 11-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RAJPARA MD				22e. ADDRESS 224 WASHINGTON HTS. WESTMINSTER			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 11-22-1985	23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Service	23d. LOCATION CITY OR TOWN COUNTY STATE Harpsford Carroll Md.
24. FUNERAL DIRECTOR NAME Thomas J. Fletek		ADDRESS 254 Westminster Rd 21157	25a. DATE REC'D. BY REGISTRAR NOV 25 1985
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper Pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE		
Trevor			F.			W.		
5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
June 26 1903			82 YRS.			5 4		
8. BIRTHPLACE (COUNTRY) STATE OR FOREIGN			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
U.S.A. Maryland			Carroll, Md.			Sykesville		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Golden Age Guest Home			Unknown					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		
Md. Carroll			Sykesville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Thomas ARMACOST			Julie Rineman			UNKNOWN		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
219-20-4178			MRS. Voxita Mahanna			Hampstead Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) E. Coli Septicemia								2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
Hypertension, Diabetes Mellitus, ASCVD, Azotemia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/17/79 to Now, 19, that (I) (we) last saw the deceased alive on 11/27/85, 19, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
J.H. CARICOTE MD.				ATTENDING PHYSICIAN		11/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
J.H. CARICOTE MD.				P.O. Box M, Union Bridge Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation		12-1-85		Carroll Cremation		Hampstead Carroll Md.		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Eline Funeral Home, Hampstead, Md.				DEC 6 1985		Julia T. ...		

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Mr. J. H. C. ...

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 29th inst. regarding the matter of the ...
I am sorry that I cannot give you a more definite answer at this time, but the matter is still under consideration.
I will be glad to discuss this matter further with you at any time you wish.

Very truly yours,
[Signature]

11/2/64
[Signature]

11/2/64
[Signature]

322073

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE TILGHMAN STAGG			2a. DATE OF DEATH MONTH DAY YEAR 11 6 1985			2b. HOUR 11³⁶ PM				
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 29 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.				
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL LUTH. Village H.C.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 200 ST. LUKE CIRCLE 21157	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM STEWART TILGHMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE BENSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/O N/A			16b. SOCIAL SECURITY NO. 217-14-8095		17. INFORMANT ADDRESS MRS. LOUISE STAGG SPITTEL WESTMINSTER, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) 8 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cholelithiasis; recurrent cholecystitis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) this hospital) attended the deceased from 19 1975 , to 11/6 , 19 85 , that (a) (we) lost saw the deceased alive on 11/6/85 , 19 85 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William R. O'Leary						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/7/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE NOV. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.		23d. LOCATION (CITY OR TOWN) COUNTY STATE WESTMINSTER CARROLL MD.			
24. FUNERAL DIRECTOR NAME Robert A. Myers						ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR NOV 13 1985		
						25b. REGISTRAR'S SIGNATURE John F. ...				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

BP

NAME: [illegible] [illegible]

DATE: [illegible] [illegible]

TIME: [illegible] [illegible]

LOCATION: [illegible] [illegible]

WEATHER: [illegible] [illegible]

WIND: [illegible] [illegible]

SEA: [illegible] [illegible]

WAVE: [illegible] [illegible]

SWELL: [illegible] [illegible]

STATE: [illegible] [illegible]

REMARKS: [illegible] [illegible]

WIND: [illegible] [illegible]

SEA: [illegible] [illegible]

WAVE: [illegible] [illegible]

SWELL: [illegible] [illegible]

STATE: [illegible] [illegible]

REMARKS: [illegible] [illegible]

WIND: [illegible] [illegible]



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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY OTHERS ARE NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES M. WINPIGLER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 11 DAY 19 YEAR 85	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH April DAY 2 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH 11 DAY 19 YEAR 85		2d. HOUR 11 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 402 Barnes Ave., 21157			
14. FATHER'S NAME FIRST Charles MIDDLE LAST Winpigler				15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Mrs. Irene Myers, 885 Stone Rd., Westminster, Md. 21157							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard A. Jones				TITLE (SPECIFY) Deputy				DATE SIGNED 19 NOV 85			
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones				ADDRESS Carroll County General Hosp							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick, Frederick COUNTY Md. STATE 			
24. FUNERAL DIRECTOR Smith, Keeney and Baxford Funeral Home 106 East Church Street, Frederick, Md. 21701						25a. DATE REC'D. BY REGISTRAR NOV. 25 1985		25b. REGISTRAR'S SIGNATURE John Andrew Rindell			

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wilbur F Yingling			2a. DATE OF DEATH MONTH DAY YEAR 11-25-85			2b. HOUR 4:45 AM				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 6 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE MD			13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1412 Deer Park Rd. 21048	
14. FATHER'S NAME FIRST MIDDLE LAST William Nelson Yingling					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura E. Busch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 215-42-1074		17. INFORMANT 5100 Bartholow Road Wm. G. Yingling Sykesville, MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio Pulmonary Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Abdominal Mass - Colonie**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Probable Carcinoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

> 1 year

> 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Anemia with Heme Positive Stool; AS4D, Status post Poremake

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/23 , 19 85 , to 11/25 , 19 85 , that (II) (we) last saw the deceased alive on 11/20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William R. Lawrence				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 11/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/29/85		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD	
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD				25a. DATE REC'D. BY REGISTRAR DEC 05 1985		25b. REGISTRAR'S SIGNATURE Julia Anderson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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